

## DoD Smallpox Response Plan

**Department of Defense**  
Washington, DC

**Smallpox Response Plan**  
29 September 2002

### REFERENCES

- a. CJCS Contingency Plan (CONPLAN) 0500-98, Military Assistance to Domestic Consequence Management Operations in Response to a Chemical Biological Radiological, Nuclear or High-Yield Explosive Situation. 11 February 2002. (For Official Use Only, FOUO)
- b. Combatant Command Contingency Plan (CONPLAN) Series 0400 (Counterproliferation).
- c. Combatant Command Operations Plan (OPLAN) Series 1067 and 5027.
- d. Centers for Disease Control & Prevention (CDC). Smallpox Response Plan & Guidelines, 23 September 2002. <http://www.bt.cdc.gov/DocumentsApp/Smallpox/RPG/>.
- e. Army Regulation 40-12, SECNAVINST 6210.2A, Air Force Joint Instruction 48-104. Quarantine Regulations of the Armed Forces. 24 January 1992. [http://www.usapa.army.mil/pdffiles/r40\\_12.pdf](http://www.usapa.army.mil/pdffiles/r40_12.pdf).
- f. Army Regulation 525-13. Antiterrorism. 4 January 2002. [https://akocomm.us.army.mil/usapa/epubs/DR\\_pubs/DR\\_b/r525\\_13.pdf](https://akocomm.us.army.mil/usapa/epubs/DR_pubs/DR_b/r525_13.pdf).
- g. World Association of Disaster & Emergency Management, Health Disaster Management. Guidelines for Evaluation & Research in the Utstein Style, March 2001.
- h. Advisory Committee on Immunization Practices. Vaccinia (smallpox) vaccine. *MMWR* 2001;50(RR-10):1-25. <http://www.cdc.gov/mmwr/PDF/rr/rr5010.pdf>.

#### 1. Situation.

##### a. General.

(1) Purpose. This plan provides implementing instructions and accompanying planning guidance to prepare for and respond to a smallpox outbreak. A single case of smallpox outside of an approved laboratory constitutes a smallpox outbreak. This document amplifies and implements the Smallpox Response Plan & Guidelines issued by the Centers for Disease Control & Prevention (CDC). This DoD Smallpox Response Plan provides for response to smallpox outbreaks on military installations and contingency operations around the world, as well as military support to civil authorities.

## DoD Smallpox Response Plan

(2) Applicability. This plan applies to uniformed departments of the Air Force, Army, Navy, Marine Corps, and Coast Guard (Active and Reserve), nonmilitary persons under military jurisdiction, selected Federal employees, and family members and other people eligible for care within the military health care system.

(3) Summation. Appendix 1 summarizes this document on one page. Similarly, the first appendix to each of the annexes summarizes that annex. Appendix 4 provides a summary of tasks specified in this plan and its accompanying planning guidance.

b. Contagious Disease. Smallpox is a contagious, sometimes-fatal infection that can be prevented by vaccination with live vaccinia virus (Appendix 3). Although a World Health Organization (WHO) global campaign eradicated naturally occurring smallpox by the late 1970's, there remains concern that clandestine stores of smallpox virus could be used as a biological weapon (BW). If an outbreak of smallpox occurred, several factors could contribute to a more rapid spread of smallpox than seen before this disease was eradicated (e.g., fewer people with immunity, delay in recognizing an eradicated disease, more immunodeficient individuals, greater individual mobility). Because of these factors, a single case of smallpox would require an immediate and coordinated public-health and medical response to contain the outbreak.

(1) Effect on Readiness. A smallpox outbreak would significantly affect military readiness. An outbreak would degrade combat-mission capability among vulnerable troops; stress military medical operations to maximum capacity; restrict military operations; limit transit of international boundaries; and divert military manpower for health care or crowd control.

(2) Smallpox Disease. Smallpox is a contagious disease caused by the variola virus. Historically, smallpox killed 30% of those infected, on average. Smallpox involves sudden fever, malaise, headache, vomiting, and eruption of a deep-seated rash. The lesions of this rash contain live variola virus. The hemorrhagic and flat (confluent) forms of smallpox killed nearly all those who developed those forms. Survivors of smallpox can be severely scarred, especially on the face. Rarely, smallpox causes blindness.

(3) Transmission of Smallpox. Variola virus causes a strictly human disease that spreads naturally only from one person to another. There are no natural animal or insect reservoirs or vectors. The most common way of being infected with smallpox is to inhale the virus on droplets during face-to-face contact ( $\leq 6$  feet) with a contagious person. Direct contact with infected skin lesions would also transmit the virus. Indirect transmission, such as contact with inanimate objects (e.g., contaminated bed linens) carrying smallpox scabs, was uncommon. Deliberate transmission by aerosol may be possible.

c. Threat Assessment. Smallpox has been eradicated; the last natural case occurred in 1978. However, smallpox remains a biological threat, because of remaining viral stocks. Smallpox virus could be released in either military or civilian settings, or both. The appearance of one case of confirmed smallpox (other than an accidental exposure in one of the two internationally approved storage facilities) indicates probable use of smallpox as a

## DoD Smallpox Response Plan

BW agent. Release of smallpox as a biological weapon constitutes an outbreak. The release could be from a point source or in a multifocal manner. The outbreak could begin with index cases in many locations within a nation or within multiple nations, resulting in a pandemic (a widespread epidemic).

(1) Smallpox Stocks. By international agreement, only two repositories are approved for stocks of smallpox virus, one at the CDC in Atlanta and one at the Research Institute for Viral Preparations in Moscow (later moved to the State Center for Virology and Biotechnology) in Koltsovo, Russia.

(2) The Soviet Union weaponized tons of smallpox viruses. Several countries are suspected of trying to develop smallpox as a biological weapon.

(3) Intentional release of smallpox (variola) virus as a bioweapon could result in widely dispersed smallpox cases. Disease could cross population lines, from military to civilian communities, and vice versa. Major disruptions in civil, political, medical, and economic order could follow.

d. Smallpox Vaccine. Historically, smallpox vaccine protected more than 95% of healthy people who received it. Studies published in 2002 by Frey and colleagues showed that ~98% of people who received either full strength Dryvax-brand smallpox vaccine or Dryvax diluted 1:5 developed the classic pox lesion at the vaccination site that signifies vaccine "take." Smallpox vaccine contains live vaccinia viruses, which evokes an immune response that protects against variola virus, the virus that causes smallpox. The WHO's use of smallpox vaccine was key to eradicating natural smallpox. Current supplies of smallpox vaccine are limited because production ceased in the early 1980's. Additional supplies of smallpox vaccine are being produced now, using more modern production methods.

(1) Adverse Reactions After Smallpox Vaccination. Like all vaccines, smallpox vaccine can cause rare but serious adverse reactions. However, smallpox vaccine causes an unusual set of potential adverse reactions, unlike other vaccines. These characteristics will warrant additional education, screening, and monitoring before, during, and after smallpox vaccination. For every 1,000,000 doses of smallpox vaccine given to previously unvaccinated adults, several serious adverse reactions can be expected, based on historical experience. The side-effect rates that follow are based on data collected in the United States during the 1960s, when about 300,000 adults got their first smallpox vaccination and over 4 million adults got repeat smallpox vaccinations (re-vaccinations).

(a) 600 cases of auto-inoculation (also called accidental infections, i.e., touching the vaccination site and then transferring vaccinia viruses to eyes, genitals, or other itchy body sites). Vaccinia virus can also spread to contacts of vaccine recipients by touch.

(b) 60 serious skin reactions (e.g., progressive vaccinia, eczema vaccinatum).

(c) 8 serious neurologic reactions (e.g., post-vaccinal encephalitis).

## DoD Smallpox Response Plan

(d) 1 to 5 deaths due to vaccination reactions (usually due to progressive vaccinia, post-vaccinal encephalitis, or severe eczema vaccinatum).

(e) Treatment of patients with some of these disorders with an antibody preparation called vaccinia immune globulin (VIG) or an antiviral compound called cidofovir may be of value (Annex H).

(2) Groups Susceptible to Adverse Vaccine Reactions. Several groups of people are known to be more likely to develop the adverse reactions listed above than the general population, but the relative risk is unknown. During pre-outbreak vaccination programs, these people would generally receive a medical exemption from smallpox vaccination. During a smallpox outbreak, however, the benefit-risk balance would shift, and public-health authorities would recommend that many of these people be vaccinated (Annex B). Some of the clinical conditions warranting caution with smallpox vaccination include: atopic dermatitis (including history of it), other chronic skin conditions, altered immune states (e.g., AIDS, cancers), and pregnancy.

e. Friendly Forces. An integrated, effective response to a smallpox outbreak will require extensive coordination between diverse Federal agencies (e.g., DoD, DHHS, CDC, Federal Emergency Management Agency (FEMA), FBI), as well as state, territorial, and local public-health activities. DoD is unique in that it has both national healthcare policy responsibilities (similar to DHHS/CDC) and the equivalent of state and local healthcare delivery responsibilities. Thus, the DoD Smallpox Response Plan must outline the critical activities at the installation, regional, national, and international levels. The Department of Defense adopts the CDC Smallpox Response Plan as the foundation for DoD's response to a smallpox outbreak. This document provides specific detail for planning, implementation, and execution of military actions in response to an outbreak of smallpox in either US or overseas theaters of operation. The DoD response will be rapid, scalable, modular, and in support of the CDC Smallpox Response Plan.

### f. Assumptions.

(1) If smallpox virus is intentionally released as a biological weapon, it will not have been genetically modified to evade protection offered by current or future smallpox vaccines.

(2) Global mixing of population. Assume uneven, but widespread, mixing of infected and uninfected personnel in and between the US and its allies during the early, uncontrolled phase of a smallpox outbreak via modern mass transportation systems.

(3) Given the 7- to 17-day (typically 12- to 14-day) incubation period between exposure and symptoms, generations of smallpox cases will arise at intervals of roughly 2 to 3 weeks. A smallpox outbreak could persist for months or years before public-health officials regain control over the disease. In other words, a smallpox outbreak would not spread peak over a few days (as inhalational anthrax cases might). Rather, smallpox cases would appear over the course of weeks, with the outbreak evolving over months.

## DoD Smallpox Response Plan

(4) Routine vaccination of US military recruits against smallpox was intermittent after 1984 and discontinued in 1990. Routine vaccination of US civilians ceased in about 1972. Thus, susceptibility to smallpox is universal among children and young adults, and widespread among older adults.

(5) People vaccinated more than 10 years ago retain some partial immunity against smallpox (Mack, 1972), but they warrant revaccination to increase their immunity. Military personnel (now senior officers and senior NCOs) vaccinated in the 1980s have an estimated 7% chance of death, if infected with smallpox. Military personnel vaccinated in the 1970s would have an ~ 11% case-fatality rate. These rates are high enough to warrant revaccination to protect them.

(6) Response to the malicious release of variola virus may be required while military forces are simultaneously engaged in armed conflict.

### g. Legal Considerations.

(1) Military commanders' actions regarding isolation or quarantine on a military installation of infected or possibly infected DoD and non-DoD personnel will be determined by the nature of the outbreak and the laws, regulations and policies concerning those specific types of situations, especially regarding people other than military personnel. Commanders must obtain legal and medical advice on individual situations from their legal and medical staffs. Local legal advice will reflect state law and coordination with civilian authorities.

(2) The Robert T. Stafford Disaster Relief and Emergency Assistance Act, P.L. 93-288, 42 USC 5121. Under the Stafford Act, a Governor may request that the President declare a major disaster or emergency if an event is beyond the combined response capabilities of the affected state, territorial, and local governments. Based on the severity and magnitude of the situation, the President may issue a major disaster or emergency declaration. Following a declaration, the President may direct any federal agency to use its authorities and resources in support of state and local assistance efforts. If an emergency involves an area or facility for which the federal government exercises exclusive or primary responsibility and authority, the President may unilaterally direct the provision of emergency assistance. The Governor of the affected State will be consulted if possible. Under the Stafford Act and DoD Directive 3025.1, commanders retain their "immediate response" authority.

(3) Law Enforcement. Under the Posse Comitatus Act (18 USC 1385 and other federal law, e.g., 10 USC chapter 18), and under DoD policy, military personnel in a Title 10 duty status (as distinguished from Title 32 National Guard duty status) generally may not participate in law-enforcement activities within the United States, except as otherwise authorized by statute or the Constitution. Consequently, military personnel acting under Title 10 shall not collect evidence; interrogate witnesses or suspects; engage in searches for or seizure of evidence; seize, arrest, or apprehend civilians; or otherwise operate as law-enforcement officers, unless specifically authorized by law. Law-enforcement assistance is

## DoD Smallpox Response Plan

not ordinarily part of consequence-management operations. The National Guard, when performing state active duty under Title 32, is not bound by the prescriptions of the Posse Comitatus Act.

(4) Quarantine Enforcement. Title 42 United States Code section 97 (42 USC 97; Appendix A-5) authorizes military officers commanding any fort or station upon the seacoast to enforce quarantines or other restraints established by the health laws of any State respecting vessels and ports, and “all such officers of the United States shall faithfully aid in the execution of such quarantines and health laws, according to their respective powers and within their respective precincts, and as they shall be directed, from time to time, by the Secretary of Health and Human Services.”

(5) Use of Weapons. Military personnel do not typically carry weapons when operating in a consequence-management role. If ordered, units may deploy to sites of BW attacks with their weapons in storage, in case the unit is subsequently authorized to carry arms by the Secretary of Defense or is deployed from the site to an assignment where weapons are authorized. The military on-scene commander is responsible to ensure that weapons and ammunition are adequately stored and physically secured at the site of the BW attack. In an emergency situation and then only when expressly authorized by the Secretary of Defense, in consultation with the Attorney General, units providing consequence-management support may be authorized to carry arms.

(6) Guidance on Intelligence Collection/Sharing. In a domestic consequence-management environment, DoD may have limited or no authority or responsibility for the collection of intelligence. In the context of a terrorist threat or acts of terrorism, the FBI, as the lead federal agency (LFA), has the overall responsibility for assembling, analyzing, and disseminating intelligence, whether of domestic or foreign origin, on the operating environment. Effective DoD consequence-management support will require obtaining information concerning the operational environment in which specific consequence-management tasks are to be conducted. Most of this information on the operational environment is unclassified data, available from open sources, passive observation, and liaison. DoD collects and shares information to support consequence-management operations in accordance with the Federal Response Plan (FRP).

2. Mission. DoD will immediately prepare to respond to a smallpox outbreak in accordance with this document. In case of smallpox outbreak, DoD will conduct response operations in accordance with this document to contain and halt the outbreak, preserve combat readiness, save lives, and prevent human suffering. When authorized by the Secretary of Defense, DoD will provide support to civil authorities in accordance with the Federal Response Plan.

3. Execution.

a. DoD Intent.

## DoD Smallpox Response Plan

(1) General. US military forces must remain dominant across the full spectrum of military operations, able to engage adversaries in any theater concurrent with support to the civil authorities who will lead our national response to a smallpox outbreak. The desired end state for this military response will be achieved with the smallpox outbreak is contained, designated personnel have been vaccinated, and further consequence-management activities have transitioned to civil authorities.

(2) Response of US Military Forces. For a smallpox outbreak on a military installation, commanders will take immediate action to counter a biological attack under provisions of applicable laws and directives. For a smallpox outbreak outside a military installation, DoD support to civil authorities will follow DoD Directive 3025.15 (Appendix 2), and subparagraph (3) below. DoD will provide administrative and medical responses (e.g., a search-and-containment strategy), as well as minimizing operational impact through vaccination of targeted subpopulations (i.e., wide-area vaccination, Appendix 5). Wide-area vaccinations are more likely to be needed if a smallpox outbreak occurs while military forces are simultaneously engaged in armed conflict, to preclude restrictions of movement. DoD will act in support of the Federal Response Plan.

(3) Support to Civil Authorities. US military forces will support DoD-approved requests for military assistance and provide DoD capabilities to respond to the consequences of a consequence-management situation in the US, its territories, and possessions. While maintaining command and control of DoD assets, commanders will ensure close coordination with civil authorities and the effective use of military capabilities to satisfy validated requests. Local military commanders and responsible officials of the DoD components located in the vicinity of the smallpox outbreak may, upon a civilian request, execute an immediate response within their unit capability to save lives, prevent human suffering, and mitigate great property damage (see also Appendix 2).

(4) The operational priorities of search and containment will be:

(a) Intense medical surveillance for people manifesting fever and rash consistent with early smallpox symptoms.

(b) Timely identification and vaccination of appropriate contacts of potential smallpox cases.

(c) Delineation of functional or geographic boundaries around cases or outbreaks (i.e., wide-area vaccination).

(d) Appropriate isolation of potential smallpox cases.

(e) Identification of contacts of potential smallpox cases.

(f) Other steps appropriate to the situation, including restriction of movement and/or use of personal protective equipment.

## DoD Smallpox Response Plan

(5) After an outbreak begins, the key to stopping the outbreak lies in vaccinating the right people (i.e., those who otherwise would spread the disease to others), rather than large numbers of people at random. Determining the “right” people will be a professional challenge. DoD will conduct wide-area vaccination when appropriate to maximize retention of military capabilities. Educating, isolating appropriate individuals after fever develops and providing appropriate personal protective equipment are other important tasks (Annex C).

b. Concept of Operations. A smallpox response operation will consist of six phases scoped by tasks to be accomplished. These phases, while generally sequential, may overlap in execution.

(1) Phase I. Deliberate Planning & Preparedness. Combatant commanders with responsibilities for conducting consequence-management operations in response to chemical, biological, radiological, nuclear, or high-yield explosive (CBRNE) incidents will initiate deliberate planning to support implementation of this Smallpox Response Plan. Most planning for implementation takes place at the installation and military treatment facility (MTF) level. Preparedness is the aggregate of all measures and policies taken before the event occurs, reducing the damage caused by the event. Preparedness relies upon deliberate planning activities. Preparedness involves ongoing medical surveillance for generalized febrile vesicular or pustular rash illness (GFVPRI, Annex A).

(2) Phase II. Situation Assessment & Notification. Phase II begins with the notification of a confirmed case of smallpox anywhere in the world. At that time, all military commanders and responsible officials of DoD are authorized to execute immediate response, within their capability and authority, to save lives, prevent human suffering, and limit spread of the disease on DoD installations and bases. In addition, upon a civilian request, execute an immediate response within their organic capability.

(3) Phase III. Consequence-Management Deployment. Phase III begins with the CJCS Deployment/Execute Order establishing formal command relationships, and directing deployment of forces. Phase III ends when identified forces have completed movement to the designated incident location.

(4) Phase IV. Military Consequence-Management Support. Phase IV begins with the arrival of smallpox response teams (e.g., epidemiological teams described in Annex A, specialized treatment teams described in Annex G and Annex H) at appropriate locations and ends with the determination that support is no longer required. As the scope and magnitude of any required support to civil authorities diminishes, DoD forces will coordinate with FEMA and the primary agencies under the FRP while planning for transition. Coordination will include the FEMA Disaster Field Office (DFO), Federal Coordinating Officer (FCO), and state-level DFOs.

(5) Phase V. Transition to Civilian Agencies. Although planning for transition of consequence management begins as soon as practical following the initial response, Phase V begins with formal implementation of the transition plan for those tasks and responsibilities being accomplished by US military forces to the appropriate civilian agencies.



## DoD Smallpox Response Plan

(6) Phase VI. Redeployment. Phase VI begins with the redeployment of the US military forces involved in the smallpox consequence-management operation and is complete when identified forces have returned to their previous military postures. After completing the mission, after-action reports and lessons learned will be documented in the Joint Lessons Learned Program and as otherwise directed.

c. Tasks. Appendix 4 provides a summary of tasks specified in this plan and its accompanying planning guidance.

(1) Supporting Plans. Commanders will undertake appropriate medical-contingency planning to be able to detect smallpox cases and to prepare to implement post-outbreak measures described in this document. The Combatant Commands, Services, Directorate of Military Support (DOMS), and the Joint Task Force for Consequence Management (JTF-CM) will develop and exercise DoD-specific contingency plans for response to a smallpox outbreak, building on existing DoD medical command and control assets. DoD will coordinate with allies and coalition members on smallpox-response programs.

(2) Training. Commanders will schedule, conduct, and evaluate training to meet requirements of this document. The military medical departments will train health-care providers in smallpox surveillance and response.

(3) Smallpox Response Teams. The Services will develop, train, and exercise various smallpox response teams: epidemiologic teams (Annex A), IND support teams (Annex B), and specialized treatment teams (Annex G and Annex H).

(4) Medical Surveillance. Military Treatment Facility (MTF) commanders will institute surveillance for generalized (febrile) vesicular-pustular rash illness (Annex A). The military medical departments will enhance and improve detection and surveillance programs.

(5) Biological Detectors. Biological detectors have a limited capacity to identify orthopox viruses. These detectors are in short supply and do not render warnings quickly enough to allow donning of protective equipment before exposure to the virus (i.e., they aren't quick enough to "detect to warn" locally). However, detection in one location may provide "early warning" at more distant locations in time to take preventive measures. Currently, the primary means of recognizing a smallpox outbreak will likely be the clinical diagnosis of smallpox. Earlier detection would require implementation of a near-real-time medical surveillance program monitoring patient symptoms and/or environmental sample testing. Preventive medicine teams should collaborate with any nearby reconnaissance or surveillance teams for sample collection of medical importance (i.e., food, water, soil) and referral testing.

d. Coordinating Instructions.

(1) Post-Outbreak Assessment. If a smallpox outbreak is confirmed anywhere around the world, commanders will be informed via command channels, augmented by

## DoD Smallpox Response Plan

reports in the news media. Upon notification, military commanders will evaluate their installations and units, to determine the needed intensity of medical surveillance for smallpox cases among these personnel. First, the installations and units will be categorized as “distant” or “near” to the diagnosed case(s) of smallpox. The threshold between “distant” and “near” is 1-hour ground travel time or 1 air leg from the diagnosed case(s). Next, military commanders will determine the status of their forces as either Certainly Unexposed, Probably Unexposed, or Potentially Exposed (using definitions below). Leaders then report through higher headquarters for consolidation and subsequent reporting to the Command’s Smallpox Coordination Cell. To preserve the presumed safety and health of the unexposed population, commanders will restrict nonessential movement until this assessment is completed. See Appendix J-5 and Appendix J-6 for additional discussion of restriction of movement.

(a) “Area of Interest.” The area of interest for a command includes the population and territory within 1 hour ground travel distance of the installation or territory, as well as, all locations within a single leg of air transport for airports within 1 hour of the installation.

(b) “Distant.” An operational area is distant relative to a smallpox outbreak, if the commander’s area of interest does not yet have one or more confirmed cases of smallpox among the total population in that area (i.e., military, civilian, host nation).

(c) “Near.” An operational area is near a smallpox outbreak, if the commander’s area of interest does include one or more confirmed cases of smallpox among the total population in that area (i.e., military, civilian, host nation).

(d) Certainly Unexposed. People completely isolated from *any* external contact for 18 or more days before recognition of the smallpox outbreak; e.g., naval forces at sea for greater than 18 days.

(e) Probably Unexposed. People sufficiently isolated or distant that the commander finds it unlikely that any of the population will develop smallpox (e.g., military forces that have mixed only with populations distant from currently known cases of smallpox).

(f) Potentially Exposed. Groups of people who have mixed with populations “near” to currently known cases of smallpox. Enhance fever-rash medical surveillance among these groups. These people need to be interviewed as per contact-tracing procedures described in Annex A, to assess risk of exposure on an individual basis.

### (2) Medical Planning & Response.

(a) IND Planning. Pre-outbreak planning focuses on obtaining sufficient smallpox vaccine to protect the Force and our beneficiaries. As of September 2002, the Food & Drug Administration (FDA) regulates the use of all available forms of smallpox vaccine as Investigational New Drugs (INDs). This situation may change in coming months. IND protocols require extensive education, documentation, and informed consent before

## DoD Smallpox Response Plan

administration (Annex B). Distribution of smallpox vaccine and related materials will be coordinated by the US Army Medical Materiel Agency (Annex I).

(b) DoD Response Teams. As a smallpox outbreak develops, epidemiologic investigation teams (i.e., Epi-Teams, Annex A) to augment current capabilities at military treatment facilities (MTFs) will travel to the site(s) to confirm the diagnosis, trace contacts, and assist with local control measures. If needed, Epi-Teams will be supplemented with IND Support Teams (IND Teams, Annex B) and Specialized Treatment Teams (T-Teams) to augment local resources (Annex G and Annex H).

(c) Facilities. After outbreak confirmation, patient-care plans must address patient movement and evacuation requirements, decontamination, isolation, treatment, stress management, and pain management. As a smallpox outbreak expands, installation commanders will need to provide separate places to lodge and care for smallpox cases and their contacts, outside of hospitals, while taking preventive measures to contain the spread of infection. The CDC plan refers to these as Type C, X, and R facilities (Appendix C-4). Type C facilities are intended for people with contagious smallpox. Type X facilities are intended for people whose diagnosis is uncertain (“X” for unknown). Type R facilities are residences or similar facilities for people potentially exposed to smallpox while under fever surveillance. Education, training, and communications, before an outbreak, will be critical for a prompt, disciplined, and effective response.

(d) Vaccination Policy. DoD response teams will be vaccinated against smallpox, similar to preparations for CDC and state-level response teams. Civilian authorities are currently developing policies for offering pre-outbreak vaccination to health-care workers or the public. DoD’s pre-outbreak smallpox vaccination policy is currently under development. If smallpox vaccine is administered under IND conditions, vaccination must be voluntary, with education, documentation, and informed consent. The only permissible exception would require the President of the United States to waive requirements for individual consent of Service Members under 10 USC 1107 and 21 CFR 50.23(d). The President may not waive requirements for education or documentation.

(e) Mental Health and Chaplain Services. Plan for mental health and chaplain services for emergency workers and their families, especially when these workers are deployed away from their home base. Plan for mental health and chaplain services for smallpox casualties, their contacts, and their families. Depending on the size of an outbreak, it may be appropriate for the installation community activities center to act as a family support center, in coordination with personnel from the American Red Cross, to assist the military family. Stress management teams will be used as appropriate.

(3) Force Protection. Commanders shall institute appropriate force protection measures, and coordinate with local law-enforcement officials to provide for the security of DoD personnel and equipment.

(a) Commanders whose units or installations qualify as “distant” from diagnosed smallpox cases will move to FPCON BRAVO or CHARLIE, based on specific

## DoD Smallpox Response Plan

circumstances, and initiate the appropriate response measures, Annex A. Changes in Force Protection Condition will be determined locally or by other authority.

(b) Commanders whose units or installations qualify as “near” diagnosed smallpox case will move to FPCON CHARLIE, and initiate enhanced medical surveillance for unusual fever with rash (Annex A). Commanders may distribute brochures (Appendix A-6) describing symptoms of generalized febrile vesicular or pustular rash illness (GFVPRI, Annex A) to all personnel entering the installation. Based on local conditions, Commanders may upgrade to FPCON DELTA. Changes in Force Protection Condition will be determined locally or by other authority.

(c) Smallpox transmission can be stopped by isolating people capable of infecting others. Isolate people with smallpox symptoms as soon as fever develops. But there is no infectious-disease value in isolating people who do not have symptoms. They are not contagious. While it may initially seem desirable to close installation gates to keep contagious people out, people exposed up to 18 days earlier may already be within the installation’s boundaries. As a result, restrictions imposed today will have little value until 2 or more weeks in the future. Restrictions rarely can be implemented stringently enough to be completely protective. Nonetheless, reducing the number of people visiting an installation may reduce the total number of person-to-person interactions, which may contribute to infection-control. Public-health workers will trace the contacts of smallpox cases, vaccinate them, and place them under fever surveillance. To limit the further spread of smallpox, encourage people to voluntarily limit their movements. See also Appendix J-5 and Appendix J-6.

(d) To manage large numbers of people arriving at vaccination sites, the main strategy of security personnel should be to secure a limited-access perimeter at a designated distance from the physical plant; and secure the clinic itself (interior perimeter, e.g., main and secondary entrances, front drive, parking area) and maintain order within the facility. To avoid disrupting operations at military hospitals and clinics, it may be appropriate to administer vaccinations at an alternate location (e.g., recreation center, school). Security personnel can adopt procedures by which people seeking medical care can identify themselves (e.g., signs requesting those with fever or contacts of smallpox patients to flash their cars’ hazard lights).

(e) Air Operations. In coordination with US Transportation Command (USTRANSCOM) and the Combatant Command(s), military air traffic between installations should be minimized upon notification of a confirmed case of smallpox, until the extent of the outbreak is determined and medical personnel can interview affected aircrew for presence of fever or rash, travel history and plans, and smallpox vaccination status (Annex A). Medical personnel will provide information to aircrew about personal protective equipment and other measures to reduce disease transmission. USTRANSCOM will coordinate with Combatant Commands for strategic-lift requirements, with appropriate priority given to DoD smallpox response requirements.

## DoD Smallpox Response Plan

(4) Operational Constraints. The scope of the DoD smallpox response will depend upon the geographic distribution of smallpox cases.

(a) Intelligence. In a domestic consequence-management situation, DoD has little or no authority or responsibility for the collection of intelligence domestically. In the context of a terrorist threat or acts of terrorism, the FBI, as the lead federal agency for crisis management, has the overall responsibility for assembling, analyzing, and disseminating intelligence, whether of domestic or foreign origin, on the operating environment. However, appropriate DoD medical experts may be consulted for technical advice and support, including the Armed Forces Medical Intelligence Center (AFMIC).

(b) Media Impact. The media will play an important role in reporting and shaping public opinion concerning a smallpox outbreak and consequence-management response. Any DoD response must take into account media coverage. The lead federal agency (i.e., DOJ/FBI or FEMA) is the lead agency for public-affairs guidance under the Federal Response Plan. The interagency Joint Information Center (JIC), using health risk communication, will provide information to the media. The OASD(PA) is the point of contact for all media inquiries concerning DoD support. See Annex E.

(c) Medical. During a BW attack, medical and public-health needs will be significant factors. The National Disaster Medical System (NDMS), which includes DoD coordination of participating nonfederal-fixed hospitals and DoD-provided patient evacuation, is the primary federal-level medical-response element. Other DoD medical capabilities external to NDMS may be requested, if necessary to augment or sustain the NDMS/local response to save lives and minimize human suffering. The time-sensitive nature of such requirements requires early and rapid interagency coordination. Restrictions on the use of military medical stocks and on military personnel vaccinating civilians may need to be addressed in mission planning. DoD unit commanders, upon notification of deployment in support of the lead federal agency, will need to ensure full implementation of appropriate force health protection measures.

(d) Mortuary Affairs. Despite efforts to save lives and prevent injury, BW attacks may create mass fatalities. DoD may be requested to assist in mitigating the potential health risks posed by mass fatalities. See also Joint Publication 4-06, Joint Tactics, Techniques, and Procedures for Mortuary Affairs in Joint Operations, 28 August 1996 ([www.dtic.mil/doctrine/jel/new\\_pubs/jp4\\_06.pdf](http://www.dtic.mil/doctrine/jel/new_pubs/jp4_06.pdf)).

(e) Domestic Transportation Assets. Transportation of DoD and other federal personnel and assets to a domestic BW attack will be critical to a successful response. DoD transportation assets are in high demand and require advanced planning. All transportation modes should be considered to support domestic consequence-management operations. Unlike overseas deployments, ground transportation is an option in a domestic situation. Under FRP Emergency Support Function (ESF) #1, Department of Transportation's Movement Coordination Center will coordinate deployment of federal resources, including DoD resources, to support consequence-management operations.

## DoD Smallpox Response Plan

(f) Communications with Other Agencies. Planners should ensure interoperability with the interagency Joint Operations Center, as established by the lead federal agency (i.e., FBI), and take the potential requirement into account and ensure communications with all agencies are sufficient to accomplish the mission (Annex E).

(g) Noncombatant Evacuation Operations (NEO). Standard procedures for NEO operations will be followed. People evacuated may be isolated at port of entry (i.e., return to the United States), with appropriate attention to human needs, until interviews establish likelihood of exposure to smallpox (Annex A). If appropriate to the circumstances, evacuated people may be offered the choice of smallpox vaccination or isolation for 18 days, to prevent spread of disease within the United States. See also Joint Publication 3-07.5, Joint Tactics, Techniques, and Procedures for Noncombatant Evacuation Operations.

### (5) Operational Security (OPSEC).

(a) Federal, state, territorial, and local agencies conduct consequence-management operations in an unclassified forum. To ensure consistency and expeditious flow of information, DoD will be an active participant in the unclassified forum. As required, commanders will develop Critical Information Lists (CIL) containing specific information requiring protection that relate to DoD deployments and consequence-management operations. Once the CIL is developed, the threat and our vulnerability to the threat are identified and analyzed; a risk assessment of potential exploitation is made; and countermeasures are developed and executed.

(b) Notification of Strategic Forces. If a smallpox outbreak is confirmed, the Joint Staff or Combatant Commanders will notify strategic forces, with instructions to preserve the unexposed status of unit personnel, using the highest levels of OPSEC available.

## 4. Administration and Logistics.

a. Medical Materiel. See Annex I.

b. Reports. See Annex A.

5. Command and Control. As a smallpox outbreak develops, the Combatant Commander responsible for conducting consequence-management operations (e.g., Northern Command for the United States) in response to CBRNE incidents may designate a Smallpox Coordination Cell to augment the usual crisis-action process. The Smallpox Coordination Cell will consist of medical, logistics, and other relevant subject-matter experts. The Smallpox Coordination Cell will receive reports of smallpox cases and provide advice for medical and logistical support. The Smallpox Coordination Cell will coordinate with smallpox-response staff at the Military Services, the CDC, and other agencies, synchronize information exchange for military chains of command, coordinate communication with local, state, territorial, national, and international public-health authorities, and coordinate activities of DoD smallpox response teams. For example, the Cell will coordinate with the Federal

## **DoD Smallpox Response Plan**

Emergency Management Agency's Disaster Field Office (DFO), Federal Coordinating Officer (FCO), and state-level DFOs.

## DoD Smallpox Response Plan

### DoD APPENDIX 1

#### DoD Smallpox Response Plan – Summary.

1. Before a smallpox outbreak, DoD will develop, exercise and improve its smallpox response plans at command and installation levels.
  - a. Installation commanders will identify:
    - (1) Facilities other than normal hospital or clinic locations at which mass vaccinations can be effectively delivered (CDC Guide B, CDC Annex 2).
    - (2) Facilities suitable for Type C, X, or R facilities (Annex C), including plans for laundry, food service, and medical waste disposal.
  - b. Medical commanders will establish programs and policies to:
    - (1) Train healthcare providers in smallpox recognition and response (Annex A, Annex B, Annex C, Annex D, Annex F, Annex G, Annex H).
    - (2) Institute medical surveillance for general vesicular-pustular rash illness (Annex A).
    - (3) Develop, exercise plans for active surveillance during an outbreak (Annex A). Set up triage clinics to evaluate people concerned they may have early smallpox.
    - (4) Train and exercise response teams (Annex A, Annex B, Annex G, Annex H).
    - (5) Maintain a supply of shipping materials for smallpox-infected specimens.
    - (6) Report cases of fever-rash illness (defined in Annex A) via reportable-disease chain, as Serious Incident Report, to CDC, and to state or host nation.
2. Once a smallpox outbreak is confirmed:
  - a. Military commanders will evaluate their installations as “distant” or “near” to the diagnosed case(s) of smallpox. The threshold between “distant” and “near” is 1-hour ground travel time or 1 air leg from the diagnosed case(s).
  - b. Military commanders will next evaluate their units as:
    - (1) Certainly Unexposed (isolated for previous  $\geq$  18 days, e.g., naval forces at sea).
    - (2) Probably Unexposed. People sufficiently isolated or distant so exposure unlikely.
    - (3) Potentially Exposed. Groups of people who mixed with other known “near” cases.  
Do fever-rash surveillance and contact tracing to assess individual risk (Annex A).
  - c. Aircrew: Minimize military air traffic between installations upon confirmation of a case of smallpox, until extent of outbreak is determined and medical personnel can interview affected aircrew regarding fever, rash, travel, and vaccination (Annex A).
  - d. Military Treatment Facility commanders will:
    - (1) Conduct active surveillance to identify other potential smallpox cases (Annex A), augmented with epidemiologic teams (Epi-Teams).
    - (2) Isolate potential cases during evaluation, to reduce spread (Annex C).
    - (3) Identify contacts of potential cases (Annex A).
    - (4) Vaccinate contacts and their contacts (Annex B) and monitor fever (Annex C).
    - (5) Vaccinate non-contact high-risk personnel (Annex B).
    - (6) Care for smallpox patients (Annex G), with treatment teams (T-Teams).
    - (7) Care for people who develop adverse reactions after vaccination (Annex H).
  - e. Military commanders will communicate with their communities (Annex E).
3. As a smallpox outbreak develops, Combatant Commanders may designate one or more Smallpox Coordination Cells to coordinate the DoD response and provide a focal liaison with CDC smallpox response coordinators.



## DoD Smallpox Response Plan

### DoD APPENDIX 2

#### Military Assistance to Civil Authorities.

DoD Directive 3025.15, Military Assistance to Civil Authorities, dated 18 February 1997 ([http://www.dtic.mil/whs/directives/corres/pdf/d302515\\_021897/d302515p.pdf](http://www.dtic.mil/whs/directives/corres/pdf/d302515_021897/d302515p.pdf)), governs military assistance during times of civil emergency. It states that the “Department of Defense shall cooperate with and provide military assistance to civil authorities as directed by and consistent with applicable law, Presidential Directives, Executive Orders, and this Directive.”

DoD Directive 3025.15 also states “All requests by civil authorities for DoD military assistance shall be evaluated by DoD approval authorities.” The directive designates the Secretary of the Army as the “approval authority for emergency support in response to natural or man-made disasters....” The Secretary of the Army exercises this responsibility through the Directorate of Military Support (DOMS).

“Requests for immediate assistance (i.e., any form of immediate action taken by a DoD Component or military commander to save lives, prevent human suffering, or mitigate great property damage under imminently serious conditions) may be made to an Component or Command. The DoD Components that receive verbal requests from civil authorities for support in an exigent emergency may initiate informal planning and, if required, immediately responds as authorized in DoD Directive 3025.1 (reference (g)).”

## DoD Smallpox Response Plan

### DoD APPENDIX 3

#### Information Paper on Smallpox Infection and Smallpox Vaccine.

1. Smallpox. Smallpox is a contagious viral disease that spreads from one person to another. Smallpox usually spreads by exhaled droplets at close contact, usually face-to-face ( $\leq 6$  feet) or household contact. Smallpox symptoms (e.g., high fever, fatigue, headache, backache) begin 7 to 17 days (typically 12 to 14 days) after exposure. A characteristic rash follows in 2 to 3 days. See Appendix G-2 for a timeline from date of exposure or onset of symptoms. Smallpox kills about 30% of those infected. Survivors are often permanently scarred or, rarely, blinded. Animals and insects do not harbor nor transmit smallpox (i.e., act as reservoirs or carriers).

2. Controlling Transmission. To stop smallpox transmission, isolate people capable of infecting others. The two most important ways to stop the spread of smallpox are (a) early diagnosis and (b) cooperating with workers tracing the contacts of smallpox cases. Isolate people with smallpox symptoms as soon as fever develops. But there is no infectious-disease value in isolating people who do not have symptoms. They are not contagious. While it may initially seem desirable to close installation gates to keep contagious people out, people exposed up to 18 days earlier may already be within the installation's boundaries. As a result, restrictions imposed today will have little value until 2 or more weeks in the future. Restrictions rarely can be implemented stringently enough to be completely protective. Public-health workers will trace the contacts of smallpox cases, vaccinate them, and place them under fever surveillance. Limit installation access, but do not expect gates and fences to keep viruses outside. To limit spread of smallpox, encourage people to voluntarily limit their movements. See Appendix J-5 and Appendix J-6.

3. Contacts Defined. Face-to-face contact with a suspected, probable, or confirmed case of smallpox. Risk increases with close contact ( $< 6$  feet), increasing time of exposure (e.g.,  $> 1$  hour), and presence of rash or cough. Consider cases potentially contagious from date of onset of fever  $> 101.0^{\circ}\text{F}$  ( $38.3^{\circ}\text{C}$ ). Cases will infect about half of their household contacts. On average, each case is likely to infect 1 to 10 people.

4. Smallpox Vaccine. Smallpox vaccine protects more than 95% of healthy people who receive it. Smallpox vaccine contains live vaccinia viruses, which cross-protect against variola virus, the virus that causes smallpox. Unfortunately, smallpox vaccine causes rare, but serious adverse reactions after vaccination. Current supplies of smallpox vaccine are limited because production ceased in the early 1980's. Additional supplies of smallpox vaccines are being produced now, using purer, more modern production methods. While smallpox vaccine is very effective, personal protective equipment will be used to augment protection for the individual worker.

5. Cautions Before Vaccination. Some people are more likely to develop adverse vaccine reactions. During pre-outbreak vaccination, the following diseases would bar (contraindicate) smallpox vaccination: atopic dermatitis (and history of it), other chronic skin conditions, altered immune states (e.g., AIDS, cancers), and pregnancy. During a smallpox outbreak,

## **DoD Smallpox Response Plan**

however, the benefit-risk balance would shift, and public-health authorities would recommend that many of these people be vaccinated (see also Annex B). In post-outbreak situations, household members of contacts with these bars should either be vaccinated or isolate themselves away from vaccinated household members until the vaccination site heals.

## DoD Smallpox Response Plan

### DoD APPENDIX 4

#### Summary of Specified Tasks.

##### 1. Installation And Unit Commanders.

###### a. Pre-Outbreak.

(1) Initiate deliberate planning for implementation of the DoD Smallpox Response Plan. Plan, paragraph (para) 3b(1)(a).

(2) Schedule, conduct and evaluate training for smallpox response. Plan, para 3c(2).

(3) Identify facilities other than normal hospital or clinic locations at which mass vaccinations can be effectively delivered. Plan, Appendix 1, para 1a(1).

(4) Identify facilities suitable for Type C, X, or R facilities, including plans for laundry, food service, and medical waste disposal. Plan, Appendix 1, para 1a(2).

###### b. Post-Outbreak.

(1) Implement post-outbreak control measures. Plan, para 3c(1).

(2) Perform post-outbreak assessment of forces, then report to higher headquarters. Plan, para 3d(1).

(3) Coordinate with civil authorities for effective use of military capabilities. Plan, para 3a(2).

(4) Coordinate with law-enforcement officials to provide security of DoD personnel and equipment. Plan, para 3d(2).

##### 2. Military Treatment Facility (MTF) Commanders.

###### a. Pre-Outbreak.

(1) Initiate deliberate planning for implementation of the DoD Smallpox Response Plan. Plan, para 3b(1)(a).

(2) Undertake appropriate planning and education to detect smallpox cases. Plan, para 3c(1).

(3) Provide for education of primary-care providers, regarding recognition of adverse events after smallpox vaccination. Annex B, para 2b(4)(j).

(4) Identify facilities other than normal hospital or clinic locations at which mass vaccinations can be effectively delivered. Plan, Appendix 1, para 1a(1).

## DoD Smallpox Response Plan

(5) Identify facilities suitable for Type C, X, or R facilities, including plans for laundry, food service, and medical waste disposal. Plan, Appendix 1, para 1a(2).

(6) Identify Airborne Infectious Isolation Rooms. Annex C, para 3c(3).

(7) Consult with industrial hygiene and facilities management personnel regarding HVAC systems. Annex C, para 3c(4).

(8) Provide for smallpox specimen-collection team. Annex D, para 2b(1)(b). Maintain smallpox specimen collection kit. Annex D, para 3a.

(9) Develop procedures for emergency credentialing of healthcare workers to assist with outbreaks. Annex G, para 1c(6).

(10) Develop/enhance Respiratory Protection Program. Annex C, para 4b(1).

(11) Refine plans for providing Personal Protective Equipment. Annex C, para 3e(4)(a).

(12) Coordinate security requirements. Annex C, para 4b(4).

(13) Identify sources for increased requirements of medical supplies. Annex C, para 6a(3).

### b. Post-Outbreak.

(1) Promptly report cases of GFVPRI. Annex A, para 3a(2).

(2) Designate vaccination coordinator responsible for vaccine administration. Annex B, para 2b(3)(a).

(3) Set up triage clinics to evaluate people concerned they may have early symptoms of smallpox. Plan, Appendix 1, para 1b(3).

(4) Coordinate with local health departments to provide for contact tracing of civilians who are not DoD beneficiaries. Annex A, para 3a(7).

(5) Establish an appropriate procedure for notifying and obtaining access to contacts. Annex A, para 6b(2)(g)

### 3. Vaccination Site Coordinators.

a. Institute prevaccination screening to identify contraindications. Annex B, para 2b(3)(b).

## DoD Smallpox Response Plan

b. Provide verbal and written counseling to vaccine recipients before vaccination. Annex B, para 2b(3)(h)(ii).

c. Administer smallpox vaccinations. Annex B, para 1a.

d. Document vaccinations in electronic Immunization Tracking System. Annex B, para 2b(3)(e)(i).

e. Report daily smallpox vaccinations to higher headquarters and to CDC reporting system. Annex B, para 2c(1).

### 4. Military Medical Departments.

#### a. Pre-Outbreak.

(1) Train healthcare providers in smallpox recognition, surveillance and response. Plan, para 3c(2).

(2) Institute surveillance for generalized vesicular-pustular rash illness. Plan, para 3c(4). Plan, Appendix 1, para 1b(2).

(3) Develop and exercise plans for active surveillance during an outbreak. Plan, Appendix 1, para 1b(3).

(4) Train and exercise response teams. Plan, Appendix 1, para 1b(4).

#### b. Post-Outbreak.

(1) Promptly report cases of GFVPR. Plan, Appendix 1, para 1b(6).

(2) Be prepared to augment clinical staff of any hospital or clinic overwhelmed with smallpox patients. Annex G, para 1c(5).

(3) Manage adverse-event programs after vaccinations, including detailed adverse event reporting. Annex B, para 1a.

(4) Each MTF will periodically train laboratory staff in collection, handling, and shipping smallpox specimens. Annex D, Appendix D-1, para 2.

(5) The MTF will provide training on workplace hazards and the emergency preparedness plan. Annex F, para 2c(6).

(6) Provide administrative support for IND protocol implementation. Annex G, para 4a.

## DoD Smallpox Response Plan

### 5. Combatant Commanders.

a. Pre-Outbreak. Develop and exercise DoD-specific contingency plans for response to a smallpox attack. Plan, para 3c(1).

b. Post-Outbreak.

(1) Receive reports of smallpox cases and coordinate logistical efforts. Plan, para 3b(2).

(2) Coordinate with smallpox-response staff at CDC and other agencies, synchronize information exchange for military chains of command. Plan, para 3b(2).

(3) Coordinate communications with local, state, territorial, national and international public health authorities. Plan, para 3b(2).

(4) Coordinate activities of DoD smallpox response teams. Plan, para 3b(2).

### 6. Military Services.

a. Pre-Outbreak

(1) Develop, train, and exercise various smallpox response teams. Plan, para 3c(3).

(2) Identify, train, prepare, and equip at least two rapidly deployable Smallpox Epi-Teams. Annex A, para 6c(2)(c).

b. Post-Outbreak. Establish medical surveillance for GFVPRI through existing disease-reporting channels. Annex A, para 3a(2).

### 7. Office of the Secretary of Defense.

a. Pre-Outbreak.

b. Post-Outbreak.

(1) Approve requests for military assistance to Civil Authorities. Plan, para 3a(3).

(2) Authorize DoD forces to provide civil support IAW Federal Response Plan. Plan, para 2.

(3) Collect and share information to support consequence-management operations IAW Federal Response Plan. Plan, para 1d(5).

## DoD Smallpox Response Plan

### DoD APPENDIX 5

#### Public-Health Actions to Limit Spread of Smallpox.

	<b>Value of Smallpox Vaccine</b>	<b>Contagious Period</b>	<b>Medical Surveillance</b>	<b>Isolation to Prevent Spread</b>	<b>Isolate Until ... (see Appendix C-10)</b>
<b>Cases: People infected with smallpox</b>	None after disease develops. Consider cidofovir to treat.	From fever to scab separation.	Ask about contacts.	Yes. Hospital or type C facility (Appendix C-4).	... all scabs fall off.
<b>Suspected case</b>	Only if symptoms not due to smallpox.	If smallpox, from onset of fever > 101°F (38.3°C).	Ask about contacts.	Yes. Hospital or type C facility.	... diagnosis established.
<b>Contact: Fever, no rash</b>	Only if symptoms not due to smallpox, and then only within 4 days of exposure.	If smallpox, from onset of fever > 101°F (38.3°C).	Ask about contacts.	Yes, type C or type X facility.	... smallpox diagnosed, or 18 days after last contact with case, or 14 days after successful vaccination.
<b>Contact: Rash, no fever</b>	Only if symptoms not due to smallpox, and then only within 4 days of exposure.	If smallpox, from onset of fever > 101°F (38.3°C).	Twice-a-day temp, daily telephone contact.	Yes, type C or type X facility.	... 18 days after last contact with case, or 14 days after successful vaccination.
<b>Contact: No rash, no fever</b>	Perhaps, best within 4 days of exposure.	n/a	Twice-a-day temp, daily telephone contact.	Home (type R) with daily telephone contact. Daily activities within ~ 20 mi of home.	... 18 days after last contact with case, or 14 days after successful vaccination.
<b>Contacts of contacts</b>	Yes. If vaccine barred, isolate away from contact until contact isolation ends or vaccine scab separates (14 to 21 days).	n/a	Twice-a-day temp, daily telephone contact.	Home (type R) with daily telephone contact. Daily activities within ~ 20 mi of home.	... 18 days after last contact with contact, or 14 days after successful vaccination.
<b>No known contact -- "near"</b>	Yes, if within 4 days after exposure, with usual cautions.	n/a	Active search for fever > 101°F (38.3°C).	Avoid unvaccinated people.	Free movement 7 to 14 days after successful vaccination.
<b>No known contact -- "distant"</b>	Yes, with usual cautions.	n/a	Active search for GFVPRI.	Limit contact with unvaccinated people.	Free movement 6 to 8 days after successful vaccination.

#### Definitions

Contact – Prolonged face-to-face contact. Risk increases with close contact (< 6 feet), increasing time of exposure (e.g., > 3 h), and presence of rash or cough.

"Near" if one or more confirmed cases of smallpox among the population within 1-hour ground travel or 1 air leg.

"Distant" if no confirmed cases of smallpox among the population within 1-hour ground travel or 1 air leg.

Type C facility - (C for confirmed) Mode of shelter and care for people diagnosed with smallpox.

Type X facility - (X for Uncertain) Mode of shelter for medical surveillance of contacts of smallpox cases with fever, but without symptoms of smallpox.

Type R facility - Residential mode of housing for surveillance of vaccinated contacts of smallpox cases.



# DoD Smallpox Response Plan